South Carolina Department of Health and Human Services

Request for Financial Verification from Medical Facility

To (Facility Name):	From (DHHS Address):

Name of Applicant/Beneficiary: _____ BG Number: _____

Please provide the following information so that we may determine Medicaid eligibility for the above-named applicant/beneficiary. Return the completed form to the DHHS address listed above. Thank you for your assistance.

1. Please provide the balance in the following accounts for the dates indicated:

Account	Date	Balance
Personal Needs		
Canteen Fund		
Other		

2. What is the source of the applicant/beneficiary's income?
   ☐ Social Security ☐ SSI ☐ Veterans Benefits ☐ Contributions
   ☐ Other (specify) _____

   Who receives the income? ☐ Applicant/beneficiary ☐ Someone else
   If someone other than the applicant/beneficiary, please provide the following information about the person who receives the income:
   Name: _____ Phone Number: _____
   Address: _____

3. Does anyone contribute directly to your facility in behalf of the applicant/beneficiary?
   ☐ No ☐ Yes. Name: _____
   Amount: $ _____ How often? _____

4. Does the applicant/beneficiary receive earned income? ☐ Yes ☐ No
   If yes, state the gross amount received during the past 4 weeks: $ _____

5. Who is the responsible party/authorized representative for the applicant/beneficiary?
   Name _____ Relationship _____
   Address _____ Phone Number _____
   List other contact persons, if any: _____

6. Does the applicant/beneficiary have insurance other than Medicare/Medicaid?
   ☐ No ☐ Yes

Company Name	Policy Number	Type of Policy	Amount

_____ _____
Signature and Title of Individual Completing This Form Date Completed